Seizure Information for Wilson Creek School District

Student Name: ___________________________ Date of birth _____________ Date ____________

Parent/Guardian___________________________ Phone ________________ Cell/work ______________

Health Care Provider treating Seizure: _____________________________Phone______________________

How often does your Health Care Provider want to see your student for seizure check-up? ______________

When did your student last see the Health Care Provider? ____

Do **you think** your student's seizures may be **life-threatening**? ❑ No ❑ Yes
(If YES, please see the school nurse as soon as possible)

Does your student's **health care provider think** the seizures may be **life-threatening**? ❑ No ❑ Yes
(If YES, please see the school nurse as soon as possible)

History and Current status

How old was your student when seizures began? ____

When was the last time your student had a seizure? ____

What type of seizure does your student have? (check all that apply)
❑ Grand mal ❑ Absence or petit mal ❑ Other, explain:
Briefly describe what happens when your student has a seizure:

How long does the seizure last? _______Seconds _______Minutes _______Hours
Describe what your student does immediately after seizures:

How often does your student have a seizure? (check one) ❑ Daily ❑ Weekly ❑ Monthly ❑ Yearly
Has there been a change in your student's seizure pattern? ❑ No ❑ Yes, explain:

Triggers

Are there any situations that may cause a seizure to occur? ❑ No ❑ Yes, explain:

Are there other illnesses that affect your student's seizures? ❑ No ❑ Yes, explain:

Is there a usual time of day seizures may occur? ❑ No ❑ Yes, explain:

Are there any signs or behavior changes before a seizure? ❑ No ❑ Yes, explain:

Treatment

What medications or treatments does your student use at school and at home? ❑ None
Meds ____
Treatments ____
Does your student have any difficulty with these medications—side effects, doesn't want to take them, etc?
❑ No ❑ Yes, explain:

Does your student have any restrictions because of the seizures or the medication—activity restrictions or wears helmet? ❑ No ❑ Yes, explain:

Does your student understand the seizure condition and what he/she can do to manage them? ❑No ❑Yes
Does your student have a brother/sister/friend at school who understands the seizures? ❑No ❑Yes
Name of brother/sister/friend and grade in school____
When your child has a seizure, what does he/she call the seizure?

Describe what you do at home when your student has a seizure:

How do you want the school to treat a seizure if it should occur at school?

Parent/Guardian signature ____________________________________ Date ________________________

 RN signature _________________________Date_______________